

# Accident report from the age of 16

Last name  First name  Date of birth   
 Street  No.  Postcode  To  Insured no.

What is the best way to contact you if we have any questions?

Telephone  E-Mail

## Overview of the accident

- 1 a) Which employer were you employed by at the time of the accident?  
(If self-employed: company address and legal form)
- b) Number of hours per week?  Eight hours or more  Less than eight hours
- 2 a) If you were not in employment, why was this?  Independent means  Not in paid employment  Retired  
 Housewife/househusband  Rentner/-in  Other:
- b) Last employer prior to the accident?   
 Employed by this employer from  to
- 3 Are/were you in receipt of unemployment benefit?  Yes  No from  to

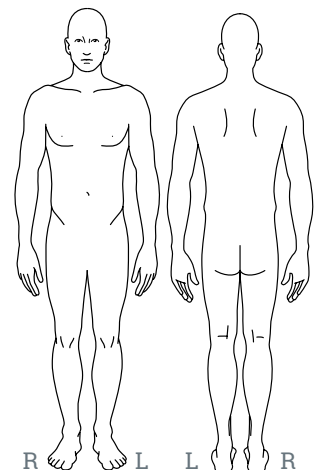
## Details of the accident

- 4 When did the accident occur? Date  Time  To
- 5 Did the accident occur on the way from or to your workplace?  Yes  No  
 Did the accident happen while you were at work?  Yes  No
- 6 Detailed description of the cause of the accident (location, weather, parties involved, vehicles, machinery, animals)
- 7 Eyewitnesses and their addresses

## Treatment

- 8 Initial treatment by doctor/hospital (address)   
 Date
- 9 Who is treating you now? (address)   
 Date
- 10 Type of injury?  
 Sprain  Torn ligament  
 Fracture  Meniskus  
 Crush injury  Cut  
 Bruising  Whiplash  
 Torn muscle  Dental injuries
- (detailed description, body part, tooth, etc.)

Indicate the injured body part



Please turn over

## Parties involved

- 11 a) Was another person to blame for the accident?  No  Yes, last name / first name and address
- b) Does the person involved have liability insurance? (If a traffic accident, see additional questions under point 15)  No  Yes, name and address of the liability insurance company
- Policy/claim no.
- 12 Is there a police report?  No  Yes, from which police station (name and address)

## Insurance details

- 13 Do you have accident insurance through your employer?  No  Yes, name and address of the liability insurance company
- Policy/claim no.
- 14 Do you have another insurance policy that covers this event?  No  Yes, name and address of the liability insurance company  
Has the accident already been reported?  
 Yes  No
- Policy/claim no.
- Type of insurance

## Traffic accidents

- 15 **Vehicle you were travelling in**  Moped/bicycle  Car  Motorcycle **Other vehicle involved in the collision**  Moped/bicycle  Car  Motorcycle
- |                     |                          |                     |                          |
|---------------------|--------------------------|---------------------|--------------------------|
| Owner               | <input type="checkbox"/> | Owner               | <input type="checkbox"/> |
| Driver              | <input type="checkbox"/> | Driver              | <input type="checkbox"/> |
| Licence plate no.   | <input type="checkbox"/> | Licence plate no.   | <input type="checkbox"/> |
| Liability insurance | <input type="checkbox"/> | Liability insurance | <input type="checkbox"/> |
| Passenger insurance | <input type="checkbox"/> |                     |                          |

- 16 **Authorisation/signature**  
The undersigned declares that he/she has answered all the questions truthfully and fully, authorises the EGK to inspect all files relating to the accident (e.g. medical documents, other insurers' files), assigns any liability claim arising from the aforementioned accident to EGK up to the amount of the benefits it has paid out and acknowledges that the EGK may assert its claims against third parties or their liability insurance providers.

Place and date

Signature of the insured person  
or his or her legal representative